VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 3, 2013

Mr. Melvin Aaron, Administrator
Greensboro Nursing Home
47 Maggie's Pond Road
Greensboro, VT 05841

Dear Mr. Aaron:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 5, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEC 26 2012

PRINTED: 12/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475043	A. BUILDING _____ B. WING _____	12/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENSBORO NURSING HOME	47 MAGGIE'S POND ROAD GREENSBORO, VT 05841

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was conducted by the Division of Licensing and Protection from 12/03/12 through 12/05/12. Based on information gathered, the following regulatory violations were cited.	F 000	1. Resident #9's care plan has been revised to reflect specific directives to nursing staff to monitor symptoms of insomnia and/or depression. The care plan has been revised to reflect current resident status. 2. All residents have the potential to be effected. All residents have had their care plans reviewed and revised to reflect their current status. 3. All licensed nurses have been re-educated as well as the social worker regarding the process for timely care plan revisions that reflect current resident status. 4. The Director of Nursing or designee will conduct random audits on care plans to ensure timely revision. 5. Weekly X4 weeks Bi-weekly X2 weeks Monthly X2 months With results reported and reviewed with the QA committee and will be reassessed quarterly.	January 5, 2013
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise the written care plan for 1 of 24 residents (Resident #9) in the stage 2 sample. Findings include:	F 280	POC accepted J. Hasnel / Frances Keller RNMSN 12/27/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Aaron	Administrator	12/20/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

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F 280	Continued From page 1 During review of the medical record and the Medication Administration Record (MAR), it was determined that Resident #9 had been receiving medications to treat insomnia and depression since admission. Additionally, behavior monitoring sheets in the medical record and MAR had been documented by nursing staff each shift. The written plan of care, which was developed upon admission, was found to lack revisions to reflect specific directives to nursing staff to monitor for symptoms of insomnia or depression. Further, the written plan of care was not revised to reflect the resident's improved status since admission, as reflected by comprehensive assessments, progress notes and staff interviews. During an interview with the Director of Nursing (DON) on 12/5/12 at 9:00 AM, s/he confirmed that the written plan of care had not been revised to either include specific monitoring directives, or to reflect changes in the resident's status.	F 280	**Food** **Procure,Store,Prepare Serve Serve, Sanitary** **1. No resident or staff member had adverse affects due to this alleged deficient practice. This is validated due to the fact that we had no widespread outbreaks of gastrointestinal illness during the period in question.** **2. As stated above, there was no indications of wide spread gastrointestinal outbreaks therefore we can conclude that there was no affect due to this alleged deficiency.**	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interview(s) the facility failed to store and prepare food under	F 371	**3. Systemic Changes to Prevent Recurrence:** **A. Dishwasher's Wash Cycle Temperature:** **A Replacement water booster will be purchased and installed.** **At the beginning of each shift water temperatures will be checked, logged and signed in a daily log book after two empty cycle runs.** **Temps must reach at least 120 degrees or Dietary and or Maintenance Supervisor must be notified as soon as possible to take corrective action.**	

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F 371	Continued From page 2 sanitary conditions. Findings include: During the initial tour of the kitchen on 12/03/12 at 9:30 A.M. with the Food Service Supervisor (FSS) the following observations were made : 1. The dishwasher's wash cycle temperature did not reach 120 degrees on two attempts per the machine's gauge and a manual thermometer. The FSS stated that the facility uses a chemical sanitizer in conjunction with the hot water. Per the manufacturer and industry standards, the wash cycle water temperature must be at a minimum 120 degrees plus 50 PPM (parts per million) of chemical sanitizer. Per review of the hot water temperature log for the months of May 2012 until present day, the wash cycle's temperature were consistently below 120 degrees. In addition, the chemical sanitizer was below the 50 PPM on 11/13/12 & 11/14/12, the water was at 118 & 119 degrees respectively on those days, and there was no record of either the water temperature nor chemical sanitizer level on 11/21/12 AM and 11/19/12 PM. 2. At the time of the observation on 12/3/12, the 3 compartment sink's water was tested to determine the level of chemical sanitizer present and the reading was below 25 PPM. Per the manufacturer's instructions, the chemical sanitizer for the first compartment should read at 200 PPM. Per review of the log book there was no documentation for the month of December, November had 4 low readings and October had only 6 out of 62 opportunities documented. 3. The vent above the cooking stove was heavily coated with grease and dust.	F 371	**A-1. Dishwasher's Chemical Check:** **Verification by each shift that there is adequate amounts of chemicals in each receptacle.** **Test strips are to be used to determine that there is at least 50ppm's in the sanitizer solution.** **The test must be logged in and signed off.** **A manual addition of sanitizer can be added to reach the 50ppm mark.** **Dietary or Maintenance Supervisor must be notified as soon as possible to take corrective action.** **B. Three Compartment Sink:** **Check the sanitizer container, under the sink, prior to using the pot sink for washing and sanitizing.** **Using pink test strips for Quits Sanitizers determine that a level of at least 200ppm's is achieved but not exceeding 500ppm's.** **These results must be recorded and signed in a log book.** **Dietary or Maintenance Supervisor must be contacted if results are not within range above.**	

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F 371	Continued From page 3 The FSS stated the vent is cleaned monthly but stated " I see what you're looking at" and confirmed that perhaps it needs to be done more often. The FSS immediately had maintenance boost the hot water temperature and contacted the service person who inspects and repairs the chemical solutions. The FSS confirmed the above observations at this time.	F 371	**C. Vend Hood Cleaning:** **Daily visual checks will be done by the morning cook and will be logged and signed off in a log book.** **If dust or grease is found on the bottom ridge screens. prior to the weekly cleaning, immediate action will need to be taken prior to continued cooking operations.** **The bottom ridge screens will be cleaned weekly, every Friday, by the morning cook and will be logged and signed for.** **4. Quality Assurance Measures:** **Revised policy and procedures have been developed to address the alleged issues.** **An series of inservice orientations have or will be conducted to thoroughly educate the dietary staff to the needed procedures and the importance of maintaining a watchful eye on the results of the tests as well as informing their Supervisors of an improper result.** **The logs and the resulting corrective actions will be reported to the Administrator and reported to the Quarterly QA meetings** **5. Substantial Compliance:** **Substantial compliance is projected to be achieved on or prior to January 5, 2013 on all three items :** **a. Dishwasher Wash Cycle Temps** **b. 3 Compartment Sink WaterSanitizer** **c. Range Hood Vent Cleaning**	